**APPENDIX B**

# Medicare Supplement
# Multiple Policies Report
# For The Year _____

Company Name: _____ NAIC # _____

Address: _____

_____

Phone Number: (_____) ____ - _____ Ext. _____

E-Mail: _____

**Due March 1, annually**

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

| Policy and Date of Issuance | Certificate # |
|---|---|
| | |
| | |
| | |
| | |

Print Name: _____ Title: _____

Signature: _____